Passport Health Plan by Molina Healthcare
Behavioral Health Service Request Form

PASSPORT HEALTH PLAN BY MOLINA HEALTHCARE

Member Information

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency Required: _____ ☐ Emergent Inpatient Admission			

Referral/Service Type Requested

Request Type:	☐ Initial Request	☐ Extension/ Renewal / Amendment	**Previous Auth#:**

Inpatient Services:

☐ Inpatient Psychiatric
☐ Involuntary ☐ Voluntary

☐ Inpatient Detoxification
☐ Involuntary ☐ Voluntary

If Involuntary, Court Date: _____

Outpatient Services:

☐ Residential Treatment
☐ Partial Hospitalization Program
☐ Intensive Outpatient Program
☐ Day Treatment
☐ Assertive Community Treatment Program
☐ Targeted Case Management

☐ Electroconvulsive Therapy
☐ Psychological/Neuropsychological Testing
☐ Applied Behavioral Analysis
☐ Non-PAR Outpatient Services
☐ Other _____

Please Send Clinical Notes And Any Supporting Documentation

Primary ICD-10 Code for Treatment: **Description:**

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

Provider Information

Requesting Provider / Facility:

Provider Name:	NPI#:	TIN#:	
Phone:	Fax	Email:	
Address:	City:	State:	Zip:
PCP Name:	PCP Phone:		
Office Contact Name:	Office Contact Phone:		

Servicing Provider / Facility:

Provider/Facility Name (Required):			
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	☐ Non-Par ☐ COC
Phone:	Fax:	Email:	
Address:	City:	State:	Zip:
For Passport Use Only:			